

FILED JAN 31 1945 318

Registration District No.

Primary Registration District No. 1003

Registrar's No. 507

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. John Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5958A Romaine Place
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Catherine Cox.

3. (b) If veteran, name war No 3. (c) Social Security No. NONE

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 3, 1900.
(Month) (Day) (Year)

8. AGE: Years 44 Months 3 Days 16 If less than one day hr. min.

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation General Office Work

11. Industry or business _____

12. Name James Cox.

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Mary Lavin

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Lavin
(b) Address 5958A Romaine Pl.,

17. (a) Burial (b) Date thereof Jan. 22/45.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.,

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.

19. (a) JAN 20 1945 J. F. Bredek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 19
year 1945 hour 12.50 minute A.M. M.

21. I hereby certify that I attended the deceased from January 31, 1945, to January 19, 1945
that I last saw h. er alive on January 19, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Myocardial infarction Uremia
Due to Severe Uremic convulsions
Due to Business of Colon (Left)
Other conditions _____
(Include pregnancy within 3 months of death)

Duration

3 days

6 days

6 mon

18 mos

Major findings:
Of operations _____

PHYSICIAN

Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address 4937 Maryland Date signed 11/9/45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Dr. S.H. Pranger,
4952 Maryland Ave.,
R.O. 3062.

1-5-40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Joe W. Deak*
Licensed Embalmer No. 1661
P. O. Address 1125 Hodiament Ave.,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)
If this body is not embalmed, fact should be so stated above.